Young Scholars Academy

PRESCHOOL & PRE-KINDERGARTEN

Taking Learning To New Heights

2-5 Years Old
All Day and Half Day Program
Enrollment Form

Student's Name _____ Enrollment Date ___/___/___
Nickname _____ Birthdate ___/___/___ Sex (circle one) F M
Home Street Address _____ Phone # _____
Mother's/Guardian's Name _____Cell Phone # _____
Employer _____ Work Phone # _____
Father's/Guardian's Name _____Cell Phone # _____
Employer _____ Work Phone # _____
Family E-Mail Address _____

Emergency Contacts (Other than Parents) and Persons Authorized to Pick-Up the Student

Name	Relationship to Student	Address	Phone #

- ○ Check if there are no emergency contacts available, other than parents.
- ○ Check if there are no persons authorized to pick up the child, other than parents.

Drop Off Schedule

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

Pick Up Schedule

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

Parent/Guardian Permissions

In case of emergency or serious illness, when parents cannot be reached immediately, I hereby authorize Young Scholars Academy to obtain emergency medical care and /or provide emergency medical transportation for my child.

_____ ____/____/____
Signature of Parent or Guardian Date

I hereby give Young Scholars Academy permission to transport my child in their vehicle for the following:

□ To and From School □ On Field Trips □ Other: _____

_____ ____/____/____
Signature of Parent or Guardian Date

Student Health Assessment

Please Write Clearly

Name of Student _____ Birthdate ____/_____/_____

Check All That Apply:

Does your student have any known allergies or sensitivities to:

	No	Yes	If yes, please list:
Medications	□	□	_____
Foods	□	□	_____
Other	□	□	_____

Illnesses of Medical Conditions:

	No	Yes		No	Yes
Asthma	□	□	Visual Impairment	□	□
Diabetes	□	□	Developmental Delays	□	□
Seizures	□	□	Physical Impairment	□	□
Heart Problems	□	□	Behavioral or Emotional Problems	□	□
Hearing Impairment	□	□	Other: _____		

List any additional health information or special instructions you feel we need to be aware of:

_____

_____

_____

List any regular medications your student takes: _____

Name of Student's Medical Provider: _____

Phone Number and Address of Medical Provider: _____

Name of Student's Dentist: _____

Phone Number and Address of Dentist: _____

Date of Student's Last Medical Exam: _____/_____/_____ Date of Student's Last Dental Exam: _____/_____/_____

_____ _____/_____/_____

Parent/Guardian Signature Date

The Student's Health Assessment must be reviewed annually by the parent/guardian, and any changes noted.

Parent Initials _____ Date reviewed ____/____/____
Parent Initials _____ Date reviewed ____/____/____
Parent Initials _____ Date reviewed ____/____/____

Parent Initials: _____ Date reviewed ____/____/____
Parent Initials: _____ Date reviewed ____/____/____
Parent Initials: _____ Date reviewed ____/____/____